Venereal Disease in Agricultural Migrants

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EACH YEAR there is a seasonal movement of migrant laborers in the United States along three principal migratory streams. These three broad patterns generally correspond to the agricultural belts of the country—the eastern seaboard, the Mississippi River Valley, and the Pacific seaboard. In 1950, the Federal Government, recognizing the multiplicity of problems associated with these workers, established a commission (*1*) to study the circumstances under which they live and work. The commission conducted hearings in Trenton, N. J., and in 10 other major cities in areas of the United States which employ migrant laborers. In 1951, it made recommendations to the President, proposing changes in administration and legislation that would benefit migratory farm workers, farm employers, and the public.

The Migrant Population

An estimated 16,000 migrant agricultural workers enter New Jersey annually. It is virtually impossible to establish their numbers with accuracy because of the variety of types of workers, their wide geographic distribution in the State, and their multiple points of origin. Among these migrants are a few hundred Jamaicans and approximately 10,000 Puerto Ricans. Farmers, working through State and Federal agencies, effect agreements with Puerto Rican and Jamaican authorities under which workers are recruited, transported to the mainland, and returned at the end of the contract period. These groups of exotic laborers contribute little to the State's venereal disease problem since, as a rule, an examination before entry into the United States screens out venereally infected individuals.

However, hundreds of Puerto Ricans who have not had the benefit of recent physical examination migrate to New Jersey from New York City and other adjacent areas. Many of these "walk-ins," as they are called in the farm labor market, originally came to the United States under a farm labor program or entered of their own accord and chose to remain. Work arrangements for the majority of Puerto Rican laborers, walk-ins and contractual personnel alike, are made through a single camp in Glassboro, which is operated by an association of farmers.

A large and homogeneous portion of New Jersey's migrant population is comprised of southern Negroes, and it is with this group that this report is primarily concerned. Having worked from Florida up the eastern seaboard with the progress of harvest seasons, these domestic migrants begin to appear in

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Cumberland, Salem, and Gloucester counties in June, and their numbers gradually increase throughout the agricultural areas until August, the peak month of vegetable harvesting activity. Few Negro migrants are found farther north than Monmouth and Middlesex Counties in central New Jersey. While some of them may remain permanently, they largely disappear from the State by the end of September.

Health and Welfare Problems

The migrant labor group contains some complete and some partial family units and brings with it a wide variety of health and welfare problems. About 65 percent of the group are males and the average age is approximately 30 years. Poverty and rootlessness, impersonal relationships, and insecurity characterize their circumstances. The nature of their living conditions, their personal anonymity, their lack of community organization encourage serious compromises with acceptable social and moral standards. Housing facilities often require that two or more families live in a single one- or two-room cabin or even in available barn space. Wages are so low (less than one-half the rate for industrial employment) that very few New Jersey residents will perform the "stoop labor" required of migrants.

The contractor or crew leader, as he is sometimes called, enters into an agreement with one or more farmers to harvest potatoes, tomatoes, and other crops on a "piece-work" basis. The contractor pays workers at a rate fixed by him. Since the urgency of hand-to-mouth economy is always present, contractors may be heavy-handed and workers are often disappointed in the remuneration they finally receive for work completed. Other migrants, known as "free-wheelers," operate as individuals or in small groups and are paid directly by the farmers for their work. In either case, migrants are employed only sporadically. According to a survey conducted by the United States Department of Agriculture, the average migratory worker in the United States in 1949 performed only 70 days of farm work. Surveys have shown that employment potentialities for such workers are at least 200 days of employment in a year.

It is under these circumstances and in this unfortunate population group that we have found the greatest prevalence of venereal disease of all groups studied.

Venereal Disease Clinics

In 1945, New Jersey enacted a law (*2*) which requires that any migrant laborer who cannot show satisfactory evidence of examination for venereal disease having been performed within 90 days prior to entering the State must submit to such examination within 30 days after entry. Moreover, the law requires that employers of migrants notify the State department of health within 5 days of the commencement of employment whether or not their workers have been examined.

Long before the passage of this law, clinics for the examination and treatment of migrant agricultural workers were maintained at strategic points throughout the State. The enactment of the migrant labor law appeared to have little effect on the numbers of migrants attending clinics. In 1952, there were 1,910 such persons examined for venereal disease.

During the period July 17 through September 9, 1953, there were available for the examination and treatment of farm migrants 4 clinics in permanent locations and a mobile unit which had previously served as a chest X-ray clinic. With 5 clinic sessions per week in the permanent sites and 5 sessions provided by the mobile unit, there were 10 clinics held every week during the period of peak migration into New Jersey.

Working from spot maps, advance men attempted to contact personally each farmer employing migrants and the contractors concerned. They were advised of the exact time and place that a given crew was expected to attend a clinic. The mobile unit was scheduled in such a manner as to cover the largest concentrations of migrant population. A centrally located farm or other place was selected as the site for the unit so that few individuals were required to travel more than 3 or 4 miles to obtain an examination.

The clinics were staffed with physicians, nurses, technicians for drawing blood, venereal disease interviewer-investigators, and clerks, the numbers of each being dictated by their

Table 1. Results of serologic tests for syphilis, by age groups

Age groups	Total tests	Number positive	Number doubtful	Percent positive and doubtful
All ages	[1] 3, 170	414	385	25. 2
Under 15	160	7	3	6. 2
15–24	1, 028	69	40	10. 6
25–34	857	124	125	29. 1
35–44	585	113	110	38. 1
45–54	338	62	72	39. 6
55–64	111	26	22	43. 2
65+	22	3	7	45. 5
Not stated	69	10	6	23. 2

[1] Excludes 231 specimens from Orchard Center-Gelston Village clinics, for which data are not available.

availability and the anticipated needs of a given clinic session. The key persons in the conduct of the program were the specialized venereal disease personnel on the staffs of the bureau and the district State health offices. They performed the duties of program coordination, scheduling and advance work, bloodletting, interviewing and investigating, and actual door-to-door canvassing just before and during clinic sessions to assure attendance at the clinics.

In most instances the staff was hard pressed to perform the tasks of physical examinations, necessary referral services, and contact interviewing of infected patients. During the summer, crews of laborers often work until nightfall. Even though clinic sessions were scheduled from 7:30 to 10:30 in the evening, and in spite of specific appointments, patients arrived in large numbers between 8:30 and 9:00 p. m., a circumstance which limited the time during which they could be tested and examined.

Diagnosis and Treatment Policies

Patients were examined according to policies established by the bureau of venereal disease control. All persons over 12 years of age were tested serologically for syphilis. Some compromise in the matter of physical examination and diagnosis was inevitable due to the large numbers of patients processed during short clinic sessions and to the transient nature of the group. An inspection of mouth and genitalia was ordered on all males. All females with positive serologic tests for syphilis (STS); all contacts, male or female, to cases of venereal disease; and all individuals complaining of or manifesting obvious signs or symptoms of venereal disease had a more complete examination.

A presumptive diagnosis of venereal disease was permitted on the basis of objective clinical findings or one positive or doubtful result on STS. No spinal fluid examinations were done.

Table 2. Cases of venereal disease diagnosed through serologic tests and physical examination by migrant health clinics

Clinic	Total cases of venereal disease diagnosed	Brought to treatment						Returned to treatment for syphilis	Previously adequately treated for syphilis
		Syphilis				Gonorrhea	Other venereal disease		
		Total	Primary and secondary	Early latent	Other				
All clinics	[1] 967	340	19	135	186	198	4	66	359
Orchard Center-Gelston Village		9	0	4	5	5	1		
Freehold	134	55	0	10	45	24	0	16	39
Prospect Plains	206	89	4	33	52	29	1	23	64
Mobile unit	612	187	15	88	84	140	2	27	256

[1] Does not include cases returned to treatment or previously adequately treated for syphilis at Orchard Center-Gelston Village clinics.

Table 3. Results of investigation of persons with positive or doubtful results of serologic tests for syphilis

Clinic	Total suspects investigated	Suspects examined		Suspects not examined, by reasons		
		Number	Percent	Moved out of jurisdiction	Cannot locate	No disposition after 30 days
All clinics [1]	799	764	95. 6	10	20	5
Freehold	120	110	91. 7	1	9	0
Prospect Plains	194	183	94. 3	0	6	5
Mobile unit	485	471	97. 1	9	5	0

[1] Excludes Orchard Center-Gelston Village clinics.

Because of the unique followup problem which the mobility of migratory labor introduces, single-treatment schedules were recommended. For syphilis, 4,800,000 units of procaine penicillin in oil with 2 percent aluminum monostearate (PAM) were given in a single administration of 1,200,000 units at each of four sites in the buttocks. The treatment for gonorrhea was 600,000 units of PAM. All contacts of primary and secondary syphilis and of gonorrhea were treated prophylactically. When an individual with a positive or doubtful result on STS gave a fairly reliable history of previous treatment, he was not required to return for re-treatment.

Evaluation of Control Program

Tables 1–4 summarize venereal disease control activity in the migrant health program during the summer of 1953. Nearly 65 percent of the individuals tested were under 35 years of age with the greatest number falling into the 15–24 age group (table 1). Because of this preponderance of young, sexually active individuals, it is not surprising that 19 cases of primary and secondary syphilis, 135 cases of early latent syphilis, and 198 cases of gonorrhea (table 2) were found in this survey of 3,401 persons. Of 3,170 blood tests on which complete data are available, 799, or 25.2 percent, were reactive for syphilis (table 1). Using the Mazzini test, 414, or 13.1 percent, were distinctly positive, with results of 3 plus, or greater, in the undiluted serum.

Tables 2 and 3 indicate program activity for each of the clinics for migrants. Very few data were available from the Orchard Center-Gelston Village clinics. Table 3 shows that practically all persons who had positive tests for

Table 4. Results of venereal disease contact interviewing and investigation

Diagnostic categories	Number patients interviewed	Contacts obtained	Contact index	Investigations assigned [1]	Results of contact investigation		
					Number examined	Infected with disease of patient	Given prophylactic or epidemiological treatment
Syphilis:							
Primary and secondary	15	48	3. 20	7	6	2	2
Early latent	29	99	3. 41	6	6	3	0
Other	1	1	1. 00	1	1	1	0
Gonorrhea	121	153	1. 26	128	99	43	49
Other venereal disease	2	5	2. 50	0	0	0	0

[1] Difference between these figures and contacts obtained represent out-of-State referrals for which no results are available.

syphilis were returned for examination. Those who had left the State were referred to out-of-State health departments for investigation. The exceptionally high proportion of individuals returned for evaluation was the result of two factors: followup within 36 hours after testing and followup by the same person who referred the migrant to the clinic for his initial examination. A significantly larger proportion of patients examined in the mobile unit had clinical symptoms of infectious venereal disease than did those seen in permanent clinics (table 2). Of the 608 cases of venereal disease treated in all clinics, 356 were communicable or potentially so. These figures represent an inordinately high incidence and prevalence of venereal disease.

The difficulties imposed by transiency of the migrant group, crowding at clinic sessions, and shortages of personnel made it expedient to emphasize serologic testing and examination of as many persons as possible rather than complete epidemiological followup. The objective of the contact interview with gonorrhea patients was to identify those sexual contacts who were known to be in New Jersey. Marital partners comprised the majority of the 25 gonorrhea contacts referred to other States (table 4). An effort was made to elicit information about all contacts of syphilis patients regardless of their whereabouts. The ready accessibility to the clinic of female gonorrhea contacts created a unique interview-investigation pattern. Since crews often attended a clinic en masse, females named as contacts by males could often be summoned by name and treated epidemiologically immediately following the interview.

Summary and Conclusions

1. An estimated 16,000 migrant laborers were employed in agriculture in New Jersey during the summer of 1953.

2. Of an estimated 6,000 domestic Negroes in this labor force, 3,401 were tested serologically for syphilis.

3. Notwithstanding the bias in age, color, sex, and socioeconomic factors, venereal disease incidence and prevalence among migrants employed in agriculture is extremely high.

4. On the basis of the results obtained by surveying this group, it is recommended that serologic surveys and other control measures be expanded wherever possible to include the entire domestic migrant population.

5. A mobile clinic is more effective than the conventional type of clinic in reaching the farm migrant group.

6. This program of intense diagnostic and therapeutic effort among a selected population group was, we believe, epidemiologically successful, efficient, and economical.

REFERENCES

(1) U. S. President's Commission on Migratory Labor: Migratory labor in American agriculture. Report of The Commission. Washington, D. C., U. S. Government Printing Office, 1951.

(2) New Jersey Laws, 1945, c. 102. Approved Apr. 7, 1945.

Departmental Announcement

George P. Larrick has been appointed Commissioner of Food and Drugs, Department of Health, Education, and Welfare, to succeed Charles W. Crawford, who retired on July 31, 1954.

Formerly deputy commissioner of the Food and Drug Administration, Mr. Larrick as commissioner will direct the administration and enforcement of the Federal laws regulating the purity, safety, and truthful labeling of foods, drugs, medical devices, and cosmetics shipped in interstate commerce.

Mr. Larrick entered the Federal service in 1923 as an inspector for the Bureau of Chemistry, which later became the Food and Drug Administration. He served successively as administrative assistant from 1928 to 1930, as senior inspector from 1930 to 1939, as chief inspector from 1939 to 1945, and as assistant commissioner from 1945 to 1948. He become associate commissioner in 1948 and deputy commissioner 3 years later.